Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHMASTERS DME
4646 N. MESA, SUITE B
El PASO TX 79912-6104

Respondent Name
OLD REPUBLIC GENERAL INSURANCE

Carrier's Austin Representative Box
Number 44

MFDR Tracking Number
M4-12-3200-01

MFDR Date Received
June 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HealthMasters (contact person) confirmed benefits with Gallagher Bassett on the above mentioned patient…When (contact person) confirmed benefits she was told that authorizations were only necessary on claims exceeding $1000.00. The claim was then billed and denied stating that the denial was due to the claim exceeding $500.00…"

Amount in Dispute: $819.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not respond to this medical fee dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2011 through January 1, 2012	E0935-RR-LT	$819.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 defines the health care that requires preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits
   - 19 – precertification/authorization/notification absent
   - 12 – submission/billing error

Issues

1. Is preauthorization required for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (p) states, "Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)." A review of the submitted bill shows that the requestor billed 21 days of cumulative rental for a continuous passive motion exercise device (E0935-RR-LT). This DME requires preauthorization.
2. A review of the submitted documentation does not support that preauthorization was requested prior to rendering the service. Reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature

		March , 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.